Summer 2004
Vol. 16 No. 3

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Kevin Johnston, CMPE

Do you encounter daily challenges in dealing with issues? AAP certainly provides the opportunities to interact with others facing similar challenges. You can network at the Spring or Fall Educational conference and learn from the presenters. You can use the listserv to ask a question at aap@adminpsych.org. You can get support through the website at http://www.adminpsych.org/. As was evident at the Spring Educational Conference, AAP members have a wealth of information to share through presentations and networking. For those members who have not attended a conference or participated in the listserv, I encourage you to do so as you have much to offer to others and my hope would be that you would take away new knowledge that would benefit you. Just ask me how you can be involved (kjohnsto@iupui.edu or 317-274-1222).

With forty-three attending the Spring Education Conference in Seattle, we were truly blessed with new perspectives as we interacted. It was nice to start new friendships and it was wonderful to be with old friends. AAP is unique in our relationships and desire to share. If you have not experienced this unique relationship, please do so at our Fall Education Conference in Boston, November 6th or in New York at the next Spring Educational Conference, April 16th. The planning committee for this past confe**rence, consisting of Chris Williams** (Indiana U), **Pat Sanders Romano** (Albert Einstein COM), **Liz Smith** (Thomas Jefferson U), **Jackie Rux** (Medical College of Wisconsin), **Elaine McIntosh** (U Nebraska), **Jim Landry** (Tulane U), **Margaret Moran Dobson** (Medical College of Ohio) and **Joanne Menard** (U Washington) provided such a robust program. Your 2003-04 Board members, **Dan Hogge** (U Utah), **John DiGangi** (U Massachusetts), **Pat Sanders Romano**, **Elaine McIntosh**, **Jim Landry**, **Jackie Rux**, **Brenda Paulsen** (U Arizona) and **Warren Teeter** (Wake Forest U) provided the collegial environment for us to share in so many ways. I encourage you to contact each one to thank them for all they do, along with **Jan Price** (U Michigan) for her continued support in all areas and **Rich Erwin** (U Missouri) for his website and listserv support.

Pat will need your help in planning for the Boston conference, so don't hesitate to let her know you want to help or do a presentation (promano@aecom.yu.edu). Certification in ACMPE requires

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Comings and goings

If there are new AAP members in your state, please feel free to call them and personally welcome them to our organization. One of the things that makes AAP special is its friendly members! The hospitality offered by a personal contact will surely be appreciated.

AAP wishes to extend a warm welcome to the following new members:

Toni Ansley
Ohio State University
ansley-1@medctr.osu.edu
(614) 293-9475

Dwayne Clayton
Louisiana State University-Shreveport
dclayt@lsuhsc.edu
(318) 675-7260

Christina Nesbeda
U Massachusetts
christina.nesbeda@umassmed.edu
(508) 856-4397

AAP wishes good luck to **Linda Hein** (U Alberta) on her retirement.

AAP announces member recognition awards

At the Spring Board meeting, it was decided to offer three awards, beginning Spring 2005. Recipients of these awards would be determined by the Board of Directors and announced at the Spring Business Meeting during our AAP educational conference.

President's Award - This award will be given to a member determined to have made significant contributions and demonstrated long term commitment to AAP.

Board of Directors Award - This award will be given to a member who had made a significant contribution during the previous year to the ongoing activities of the organization.

Both of these awardees will receive a wall plaque, and will be recognized in *The GrAAPvine* and at the annual meeting, and their chairs will receive a letter announcing the honor.

Rising Star Award - This recognition will be given to all new members (within the first three years of membership) who have participated in a significant way in AAP activities. This could include speaking at a conference, writing an article for *The GrAAPvine*, serving on a committee, or any other activity recognized by the Board as contributing to AAP. All recipients of the Rising Star Award will receive a certificate suitable for framing, will be recognized in the newsletter and at the annual meeting, and their chairs will receive a letter announcing the honor.

These awards will be presented annually at the discretion of the Board of Directors and shall not be awarded to current Board members.

President's message

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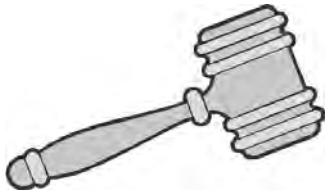
presentations, so this might be a great opportunity for you.

We recently were notified that AAP is to receive $750 from the Academic Practice Assembly because our membership had the second largest percent increase in participants completing the annual compensation survey. As I reviewed the results, 27 Psychiatry departments completed the faculty portion of the survey and 15 completed the management portion of the survey. Thank you for completing these. More departments completing the survey makes the results more informative and useful, especially as you provide sub-specialty detail.

Warren provided wonderful coordination of the Nominating Committee, as conference attendees approved your 2004-05 officers (see page 3 for a listing). I look forward to working with them this coming year and I encourage you to contact them and volunteer to help in some capacity. Both the back page of *The GrAAPvine* and our website are great locations to find their e-mail address or telephone number. As I work with this group, we will define the goals for this coming year and get them posted on the website and distribute through the listserv. I encourage you to follow this development as we try to work our strategic plan, which is also available on the website.

Communication is such an integral part of our organization. Everyone is very busy, but please find time to participate in some way. Enjoy your summer and I look forward to the opportunities before us.

Introducing the 2004-2005 AAP board of directors



The 2004-2005 AAP Board of Directors was approved at the Business Meeting in Seattle, Washington. The members of the Board welcome your comments and questions, so please feel free to contact any of them. Their e-mail addresses and phone numbers are printed on the back page of *The GrAAPvine*.

President	Kevin Johnston	Indiana University
President-Elect	Pat Sanders Romano	Albert Einstein College of Medicine
Immediate Past President	Dan Hogge	University of Utah
Secretary	Elaine McIntosh	University of Nebraska
Treasurer	Brenda Paulsen	University of Arizona
Membership Director	Steve Blanchard	University of Iowa
Member-at-Large	John DiGangi	University of Massachusetts
Member-at-Large	Jim Landry	Tulane University
Member-at-Large	Jackie Rux	Medical College of Wisconsin

This is the time of year when I get to thank everyone who has helped me to get this newsletter out this year. Without the assistance and good nature of everyone who volunteers, this job would certainly not be as easy or as much fun as it is! I continue to marvel at how lucky I am to have such wonderful friends and colleagues that all I have to do is send out an email plea and so many people step up to offer their writing skills. So thank you, thank you to everyone who over the course of this past year has written an article for The GrAAPvine. *You're the greatest!*

Jan

Radmila Cassidy
Jeff Charlton
John DiGangi
Lee Fleisher
Dan Hogge
Jim Landry, CMPE
Janice MacAdam
Elaine McIntosh
David Peterson, FACMPE
James Rodenbiker
Jackie Rux
Cynthia Smith
Mary Jo Swartzberg
Warren Teeter
Joe Thomas
Christine Williams

Congratulations . . .

. . . to **Jim Landry** on being awarded the Tulane Excellence Award. This recognition is given annually to up to ten members of the Tulane staff for outstanding performance. Individuals are nominated on the basis of four criteria: Increased Productivity, Enhanced Objectives, Cost Savings and Humanitarian. Jim was recognized in two categories: *Cost Savings* and *Enhanced University Objectives*.

While walking around Pike Street Market, I saw a tee shirt that read "The rain in Spain stays mainly in Seattle." Well, the weather sure fooled all of us who prepared for wet skies. The sun shone and the temperatures hit the 70's every day we were there, adding to the fun and camaraderie during the Spring Educational Conference! Several new members, some "old" members attending their first conference, and many "hard core" conference attendees shared Saturday together learning from each other and making or renewing friendships. Special thanks go to **Kevin Johnston** (Indiana U) and his Program Committee (see the President's message for a complete list of names) for a jam-packed educational conference. You can read all about the sessions in the following articles written by your colleagues.

But don't think that AAPs are all work and no play! Special thanks go out to Chris and Joanne for planning two delicious dinner outings. The margaritas and good conversation flowed on Friday night as we dined at Mexico. A short bus ride on Saturday through the "funky" section of Seattle (there's even a troll living under a bridge!) took us to Anthony's, a beautiful restaurant right on the water where we could watch the boats sail by and the sun set as we ate dinner.

Very early on Sunday morning twelve hearty AAPs in a three car caravan set out for the ferry to Friday Harbor in the San Juan Islands. (Thanks to **Elaine and George McIntosh** for renting the cars and to Joanne (again) for doing all of the pre-travel information gathering that made the trip so smooth). While we weren't lucky enough to see any whales, the ride was beautiful, the harbor area quaint, and the lunch on the rooftop deck of a restaurant overlooking the water relaxing, so no one missed the whales! And ask Margaret Dobson about her moped ride!

Sunday evening the APA conference started and on Monday night we partied at the conference reception. Of course the AAPs stayed 'til the bitter end (and then some) boogying the night away - or at least until 9:15 when we got kicked out! Then on to the bar for some additional socializing!

Read on for synopses of the conference presentations and photos of the fun times we had!

The William J. Newel Lecture

Integrating psychiatry into mainstream medicine

by Lee Fleisher

This year's Newel Lecture was delivered by **Richard Veith, M.D.**, chair of the Department of Psychiatry at the University of Washington.

Dr. Veith described the intent of his presentation to be a review of programmatic initiatives within his department and the links between these initiatives and certain key changes in the broader environment. In brief, the contextual background for their efforts included:

- The emergence of science within psychiatry
- The convergence of advances within psychiatry, neuroscience, molecular genetics and evidence-based medicine
- Rapidly accelerating advances, and
- Greater awareness of mental health issues in society at large.

Richard Veith, MD

In support of the above contextual changes, Dr. Veith presented three case examples: cardiac depression, familial Alzheimer's Disease and collaborative care models for depression. In each case, he compared the situation in the 1970's and 1980's with the current state of affairs. In each case, there have been significant advances and changes in the role of psychiatry and pharmacologic and therapeutic interventions in the approach to dealing with these problems.

Having laid his foundation, Dr. Veith went on to describe the strategic implications of the above

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on various spheres of activity within his department. These are summarized as follows:

Training – a focus on:
- neuroscience, genetics and pharmacology
- evidence-based medicine, especially CBT and DBT
- care of chronic complex disorders
- consultation in primary care

Research – a focus on:
- neuroscience, genetics, developmental disorders, aging and substance abuse
- outcomes, research (models of care), delivery and effectiveness
- care of complex chronic disorders and populations

Clinical – a focus on:
- chronic complex disorders, inpatient, addiction, dual diagnosis, geriatric, medically ill and borderline patients
- outpatient services limited to meeting training needs and University of Washington referrals
- expanded C/L service

In support of the above, the department is partnering with hospitals, is engaged in mission-based budgeting, and closely aligning faculty incentives with mission.

In summary, Dr. Veith quite effectively described his analysis of the external environment and forces impinging on his department and the strategic decisions they have made in response to that analysis.

(Lee Fleisher is the administrator of the Vanderbilt University department of psychiatry).

Research infrastructure

by Janice McAdam, MPA

University of Washington (UW) Psychiatry and Behavioral Sciences is one of the top psychiatric research facilities in the United States. The research infrastructure has been configured to support research in various areas of psychiatry as well as collaborations with other clinical areas. Within this structure there are five different sites that are active in research. Each site funds their own support staff and has budget support for faculty. **Claire Colson, Lisa Muth, Cristi Chapman, and Michel Vitiello, Ph.D**. presented on the various areas of the research infrastructure at University of Washington.

In order to maintain control and timeliness in grant applications, Clair Colson**,** Fiscal Operations Supervisor (FOS) has developed a workflow and timeline. The timeline starts at least ten weeks before the funding agency's deadline. The beginning of the timeline starts with the idea stage by conceptualizing the project to be funded by a faculty person who will serve as the principal investigator (PI). After preliminary discussions with Chief of Psychiatry and colleagues, a research team is assembled and the contact is made to start work on the draft budget. The draft budget, research plan and information on key personnel of research is gathered along with other required documentation and sent to the FOS at least three days prior to funding deadline.

While the PI and the research team continue to refine research plan, the FOS reviews the research infrastructure application and obtains the school of medicine signatures for the application. Three weeks prior to the grant deadline, the Grant and Contract Supervisor (GCS) reviews the budget. Once the GCS approves the budget and the research plan is finalized, the final quality control review is completed. At least three days prior to the funding agency's deadline, the research project application packet is sent to the funding agency.

Grant and Contract Administrator, Lisa Muth heads ups the Sponsored Project Offices (SPO). SPO is a resource for the PI and departments and a single point of contact for sponsors. As "ground zero" for policymaking, SPO is the compliance police through review and sign off of proposals, and negotiation of awards and establishment of accounts. SPO provides training in electronic grant administration and courses on NIH.

SPO is often seen as more hindrance than help due to often creating bottleneck for proposals. However, this is the place where the compliance function becomes value added to the process. Proposals are often completed last minute by the PI and this adds stress to everyone's life and rework time is not factored in. Electronic processing of the grant application will help meet needs of

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internal and external compliance along with approval system and deadlines.

The technology solution in grant and contract offices is to have a 24/7 global electronic sponsor system. Twenty-six agencies currently provide availability through the web site http://grants.gov/. Eleven foundations can be found through a portal for proposals at http://pc.ramscompany.com/. Institutional electronic routing will help reduce the time spent in routing because multiple reviews can happen at once and changes can be made instantaneously.

The post-award process starts when official notice of the award from the sponsoring agency. Cristi Chapman, Accounting Manager sets up a budget number and the grant is active. During the active period, invoicing and cost sharing are part of the cash flow, compliance and reporting. When the grant is complete the closing process includes expenditure compliance review, final report or invoice, deficit or balance transfer and follow-up, and final closing.

At the same time the funding processes are active so are the measurement requirements. Measurements are part of the compliance issue to get and to file on a timely basis. Automation of the measurement process is being worked on because of the large volume of research projects. The proposal is for a dashboard approach on operational performances key objectives. The continued process improvement will yield continuous review and improvement of performance measures and customer satisfaction. Reorganization of work from functional structure to school/college level will provide departments one on one time with research accounting and add quality to the project. Growth of outreach function to the campus is part of the next step in process improvement. Proposed and actual external changes will have focused resources.

According to Michael Vitiello, Ph.D., the future of the research infrastructure is in web-based processing and infrastructures built around this design. The direction of research at UW is moving to electronic submission and tracking of all research. This will enhance research reduction in paperwork leading to timely filing and more available of support staff for the PI and research teams.

Hank Williams (U Washington) surveyed the membership of AAP on the research infrastructure of psychiatry departments prior to the AAP Spring Conference. Eighteen academic psychiatry departments reported. The majority of the respondents see themselves as somewhat proactive in seeking funding for investigators by formal research administration, informal networking tools, focused and driven research divisions, and use of various research search engines.

All respondents provide some pre-award service to investigators ranging from complete pre-award support services, budget preparation, mentorship programs, and editorial support. Most respondents provide post-award service such as budget monitoring and reporting.

The number of grant proposals submitted ranged from four to as many as 219 in the FY 2003. The majority of the grant proposals submitted where to NIH. The dollar sum of proposals ranged from $2.8 million to $32 million. Total awards in FY 2003 ranged from none to 171 with the majority being from NIH. The range of indirect cost rates was from 45 to 67%. The number of PIs that were funded in FY 2003 ranged from 3 to 136.

The majority of the departments do receive some return on the indirect cost (IDC) that the institution receives from a flat fee to approximately 10% of the IDC. The biggest headaches reported were last minute grant preparation, changes in regulations, not enough time for PI to prepare proposals, complex institutional guidelines, and inconsistency in support services. One half of the respondent organizations are moving to electronic routing.

(Janice MacAdam is the associate director of the University of Kansas Medical School-Wichita department of psychiatry and behavioral science).

Medicare prospective payment system for inpatient psychiatry facilities

by Dan Hogge

Medicare has finally decided to implement a prospective payment system for psychiatric inpatient services. **Stephen Blanchard** (U Iowa) provided a succinct historical summary of the Medicare Hospital Payment System, and he provided some excellent suggestions on how to manage and prepare for this important prospective payment system (PPS) transition. To paint a picture of where we've been, where we are, and what to expect next, Steve explained our evolution from a cost reimbursement method, to the current TEFRA Payment System, and the proposed prospective payment system.

Steve reaffirmed the responsibility that we have to run the numbers and determine the impact of the proposed changes on our hospitals' bottom line. It appears that that the reimbursement will be a function of a national base per diem rate ($530) with modifiers. The hospital specific rates will be adjusted for variances in rural locations, wage indices, length of stays, age factors, and the DRG assignments.

Stephen Blanchard

A good discussion ensued on the importance of proper coding and how we need to establish policies and procedures that require accurate coding to maximize our reimbursement. There is an old adage in billing procedures that says "accurately bill for all the services you're entitled to collect to maximize reimbursement….not a penny less nor a penny more." By running some reimbursement models and doing our homework the results will provide us with a good projection of what to expect.

The proposed phase-in-period is over a four year time frame. To help the transition Steve indicated Medicare will increase the portion of the prospective payment system twenty-five percent a year, with full PPS reimbursement effective the fourth year. This transition will allow facilities a chance to implement needed procedures to adjust to the new system.

Steve drew our attention to some issues that will impact reimbursement including labor adjustments, disproportionate share payments, co-morbidity issues, and emergency room admissions. With time, Medicare will address these factors but it might not be to our satisfaction.

Steve suggested that there is a potential windfall to the hospitals for the indirect medical education costs for the residents as we convert to the prospective payment system. Take the time to understand the impact and work with your hospital administration to see how you can benefit and perhaps negotiate with them to help in your educational costs.

Overall, the new PPS system is a significant reimbursement issue that potentially may have a confiscatory impact on our hospital operations and possibly a trickle down effect to our departments.

(Dan Hogge is the administrator of the University of Utah department of psychiatry).

Where's my newsletter?

An unexpected illness and subsequent medical leave have delayed the publication of this newsletter for over a month. I apologize to those of you anxious to recieve your copy and promise that the next issue will be right on time! And thanks to all of you who inquired about my recovery. I'm doing just fine now and don't anticipate any additional time off (except for vacation and conferences, of course!)

Jan

Teaching residents

by Elaine McIntosh

Resident teaching was presented by a panel of three AAP members—**Pat Sanders Romano** (Albert Einstein College of Medicine), **Brenda Paulsen** (U Arizona), and **Doris Chimera** (U Texas Medical Branch, Galveston).

Pat presented the program agenda of the Tarrytown

Pat Sanders Romano

Leadership Conference for newly elected chief residents. Pat revealed some closely-guarded secrets about the intent of the conference exercises and some interesting anecdotes of residents' reactions to the program. The conference is held at the end of the academic year, beginning on a Thursday and running through lunch on Sunday. The purpose of the conference is to assist each resident to identify his/her leadership style through interactive exercises.

Brenda's presentation focused on her personal experience of teaching residents about the business end of psychiatry. Brenda encourages residents to enlist the aid of a contract lawyer, accountant, and financial planner as they enter the world of work. She instructs residents on the art of reading an income statement, understanding the billing operation as well as billing ratios and aged accounts receivable. Other topics that are covered in her resident teaching are employment contracting, third-party payer credentialing, dealing with the media, healthcare compliance, professional liability and risk management, and working in a non-profit environment.

Beyond the business instruction, Brenda dispenses words of wisdom in regard to loan repayment and personal financial management. Brenda's business instruction is a dose of the real world for residents.

Doris has developed a curriculum of business information in the managed care environment. Her instruction challenges residents to answer questions they most likely have not even considered as they prepare to begin their practices. She outlines the different work environments–private practice, group practice, HMO/ staff model, academic, state hospital, correctional system, locum tenens. Doris' teaching plan explains how to evaluate third-party payers and what is involved in credentialing with insurances companies. She details for her residents the providers' contract responsibilities to insurance payers and what it takes to submit claims.

Doris has done an excellent job of boiling down the hundreds of tasks that the academic administrative staff does on a regular basis to make her department's clinical practice operational. This is the behind-the-

Brenda Paulsen

scenes work that psychiatrists going into practice need to understand and assure are completed as they open their new practices.

These three presentations identified different approaches to teaching residents on a wide variety of topics. The impression that these presentations left with the audience was that as administrators, we have a great deal of useful information to offer residents as they begin their practice of psychiatry.

(Elaine McIntosh is the administrator of the University of Nebraska department of psychiatry).

Telemedicine in psychiatry

by Christine Williams

Janis Price (U Michigan) and **Rich Erwin** (U Missouri) presented the timely subject of telemedicine, sharing the types of services and mode of implementation that has been developed at each institution.

The University of Michigan department of psychiatry, in collaboration with their University Hospital and county judicial system has developed a very successful program to provide involuntary commitment hearings within the hospital setting. Prior to the telecourt commitment hearings, patients were physically transported to the courthouse, which presented security issues as well as increased costs created by staff time commitments. With full support from the judicial system to develop a telecourt program, initial start up costs totaling $30,000.00 were funded by the hospital. An existing conference room, close to the inpatient ward, serves as an extension of the court. Court is held one day a week with the patient, attorney, attending physician, social worker, patient's family, and student observers present at the hospital. The judge and prosecuting attorney are present at the courthouse. The video conferencing technology serves to make all participants feel

Richard Erwin

as if they are in the courtroom, affording increased dignity for the patients, tighter security for the hospital and staff, and decreased costs for all institutions. As on-going costs are extremely limited, Jan estimates that the projected savings over five years will be more than $100,000.00. Approximately 85 hearings are held each year, and most likely will increase to include another day a week. Jan cautions the following for limited telemedicine programs: adequate lighting and room arrangements, aggressive patient forethought, attorney dissatisfaction, and IT back up.

The University of Missouri, located in a rural state, provides the ideal setting for a telepsychiatry program. The department has telepsychiatry units that serve a 42 county area with a full spectrum of outpatient services. Most of the services are provided by residents with an on-site supervising provider. Reimbursement rates are comparable with regular on-site visits for Medicare, Medicaid, and most commercial carriers. Initial visits are face-to-face at the remote sites with follow-up visits provided from the telepsychiatry units. The system works in partnership with rural primary care physicians in prescribing medications. Every 3 to 4 months, the provider will again see the patient in person. As this program is used for most departments at the University of Missouri, there is a full IT staff to service equipment needs. Funding for this program is provided by grants from the University Library funds. Rich anticipates providing telepsychiatry services to the prison systems within four years.

(Christine Williams is the financial manager of the Indiana University department of psychiatry).

Next level performance: Executive coaching for academic administrators

by Jackie Rux

Since 2002, A**lex Jordan, MBA, CMPE**, University of Washington Department of Surgery has been involved in formal Career Development (CD) training through a CD Counseling practicum, and active in CD professional organizations such as the Puget Sound Career Development Association (of which he serves on the Board of Directors) and the University of Washington Career Development Program.

Alex introduced us to the co-active coaching model and believes that the power is in the design of the relationship where the client is always the focus. Some of the basic principles he shared are the

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power of the questions, finding the clarity of purpose and intentions, coaching as a facilitator/partner rather than an advisor, realizing that the client has or can get all of the answers himself, and understanding the importance of counterbalancing and transforming the "internal sabotages," otherwise known as "gremlins." He believes that imagery, intuition, inspiration and insights are the key to the process.

Coaching conversations include many ground rules about requests, interruptions, cognitive restructuring and commitment through accountability building. It is an evolving awareness of the power of deep mindfulness, subtle noticing and continuum thinking.

Qualifications on selecting a coach should be experience, ideally with coaching as a second career following prior executive experience. Keep in mind that most coaches have a niche targeted clientele. Make sure that they practice a philosophy that resonates with you. They should use methods that work well with your personal preference and lifestyle. Consider cost as a factor, because the average range can be from $200 to $1000 per month.

Alex feels that there are special challenges when coaching academic practice executives, such as the complexity of their jobs, which require more "set up time." They may already be functioning at a high level, therefore the coaching is more defined and perhaps a bit more difficult. This group is not used to thinking of themselves as a "primary" or a "principal." One of the most challenging issues is the time/task management components of their roles.

He feels that having academic psychiatry administrators as clients makes coaching easier because of our familiarity with psychological concepts and processes. Our belief system is already more aligned with coaching as compared to other executive groups or types. And, we have more access to resources, professionals, media and a network of peers.

Alex then put this process into practice for the group. **Values and beliefs** define a person more than anything else. They direct our development, empower or limit it. They align and harmonize us, must be made visible and held in awareness if we are to visualize and reach our next level. They are both controlled by us and control us.

The three executive performance domains are *Skills* such as negotiating, delegating, human resources; *Balance* in such areas as pace at work, eliminating "overwhelm," weekends; and *Fulfillment*, such as recognition, task enjoyment, sense of accomplishment.

The three developmental steps are *Visualizing* the development goal, *Strategizing* how to achieve the goal, and *Actualizing* the goal.

The next level of approach is to combine the performance domains and the developmental steps. Use a "continuous pattern" of visualizing, strategizing and actualizing until you hit a "breakthrough pattern" and then move to the next level executive goal. It is important to have standard goal setting features; make them realistic and achievable, measurable, communicated and have time targets.

The average executive can only work efficiently on two or three goals at a time. With a coach, they can select the "valuable few" from within any combination of performance domains. The goals selected are often the focus for several months.

Client benefits of executive coaching include clearer executive identity, increased clarity regarding direction, support during transitions and challenges, increased focus on key goals, accountability through weekly tasks, building and sustaining momentum, and identification and removal of barriers.

Finally, a quote by Wayne Dyer, PhD: "When you start to change the way you look at things . . . the things you look at start to change."

(Jackie Rux is the Financial manager, Medical College of Wisconsin department of psychiatry).

Dealing with institutional culture change

by James Rodenbiker

Radmila Bogdanich, (Southern Illinois U), **Howard Gwon** (John Hopkins U) and **Joe Thomas** (U Michigan) presented a very informative and entertaining session on "Culture Change."

Howie started off the session reviewing several definitions of culture change. Changing an organization's culture can be a daunting process. It means changing values and norms and finding methods of doing business to work more effectively, efficiently and enjoyably. Such change is usually stimulated by budgetary issues, but it is better to propose change in terms of improved quality, which reduces cost, as opposed to just focusing on the bottom line. Howard reviewed the eight stages of creating major change. One important stage is the need to communicate frequently the same message of change and the view of how things will be when the change occurs. Some faculty and staff may not buy into the change, and there may need to be voluntary or involuntary staff resignations to move the change along. Most importantly, Howie advised having a well organized plan and process so the change will move along with fewer glitches.

Radmila reviewed the process she recently went through in making a culture change in her department. She identified a multi-phase process of change including analysis of the problems, performance, and programs. It is

Joe Thomas

important to analyze the values, norms, organization support, and leadership commitment to a change. Phase two is the discussion, development and buy-in to the needed changes. This can be a very difficult stage, but essential if the change is to be effective. Phase three is when the changes are implemented, and when leadership must rally the faculty and staff to the changes. Leadership is crucial at this phase. And finally, during phase four the change is evaluated, success is celebrated, and monitoring of the change continues. Radmila's tips for success in this project included: Support the staff; Stay focused on the big picture; Give everyone an opportunity to "get on the bus;" Be patient; Make yourself indispensable; Pick your battles; and finally, Don't hire warm bodies.

Joe reviewed "a decade of change" at the University of Michigan. The presentation was enlightening as it showed that there are dramatically different perspectives on what is or even if there is a problem. The dean, chair, administrator, and faculty all had different perceptions of the problem and what to do about it. Some tasks to undertake when making a culture change include identifying what everyone wants to change (or stay the same), what are the barriers to making the changes, and how to restructure the department to make the changes. By making changes in the administrative structure of the department, there were commensurate changes in the culture via ways of thinking, values, and managerial styles. The end result was an improvement in operating efficiency, and improvement in the bottom line. However, since change is constant, the changes that were started back in 1993 now need to be revisited. And, more administrative structural changes, similar to 1993, will need to be made in 2004.

In summary, this was a fast paced, very informative, and brutally honest review of three departments with cultural changes. Not only did the presenters share their success, but they also shared the difficulties in employing change.

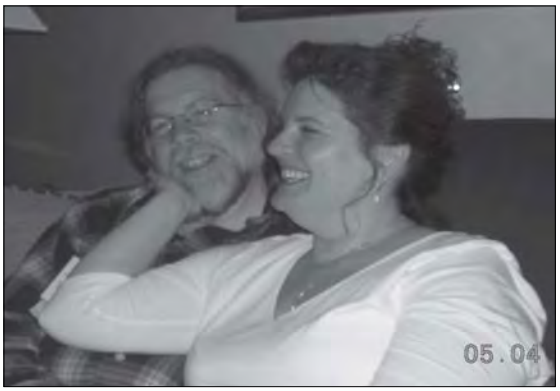
(James Rodenbiker is the administrator of the Creighton University department of psychiatry).

PHOTOS

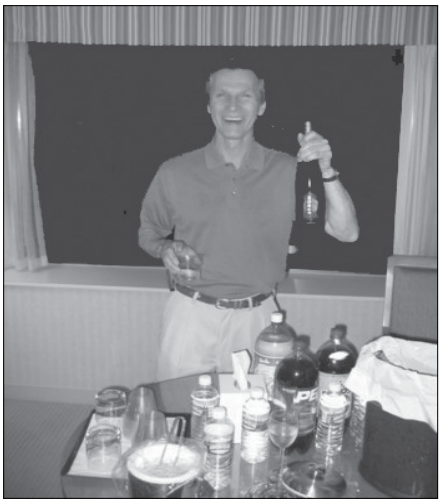
Dan Hogge and Jennifer Wood

Joanne Menard and Frank Mucha

AAP Emeritus, Al Dunn



The very happy couple, Kevin Johnston and Chris Williams



Jim Rodenbiker

Joe Thomas, Radmila Bogdanich, Jim Rodenbiker, Paul McArthur, Kevin Johnston, Chris Williams, Brenda Paulsen (back to camera)

MGMA News

Demo the MGMA survey report CDs!

Feel the power of benchmarking at your fingertips when you take a free demonstration of the enhanced interactive CDs of the *MGMA Cost Survey Report* and the *MGMA Physician Compensation and Production Survey Report*. With both of the CDs, you can:

- Benchmark your practice by geographic region and state
- Customize reports with your own data and use the built-in comparison tool
- Export tabular information to spreadsheets
- Generate graphs and reports and much more!

The demos are available at http://www.mgma.com/surveys/demo.cfm. You will need both the Microsoft Explorer browser and Windows Media Player to view the demos. After completing your free demonstration, you can purchase the CDs at:

Cost Survey Report:
http://www3.mgma.com/ecom/store/index.cfm?fuseaction=itemDetail&prod_number=6041
Physician Compensation and Production Survey Report:
http://www3.mgma.com/ecom/store/index.cfm?fuseaction=itemDetail&prod_number=6047

The CD versions of MGMA's leading benchmarking reports allow interactivity between your data and built-in tools. The CDs feature more data than their printed counterparts and offer easy custom reporting. Both CDs contain easy to use tutorials, help menus and comprehensive user manuals.

The cost for each survey CD is:
MGMA members: $415.00
Affiliate members: $465.00
Nonmembers: $515.00

After completing your free demonstration, enter your name in a drawing for $100. For questions, call toll-free 877.ASK.MGMA (275.6462), ext. 895.

Medicare incentive payments for physician care in underserved areas

Physicians, including psychiatrists, are eligible to receive ten percent bonus payments if they furnish services in primary medical care Health Professional Shortage Areas (HPSAs). Psychiatrists furnishing services in mental health HPSAs are also eligible to receive ten percent bonus payments.

Psychiatrists who qualify for these bonus payments are eligible to submit claims for services furnished in mental health HPSAs, effective for claims with dates of service on or after July 1, 2004.

Background

Under current law, Medicare pays a bonus to physicians for providing health care services in certain HPSAs. In light of recent physician inquiries, the Centers for Medicare & Medicaid Services has issued instructions to clarify which types of geographic HPSA (primary medical care, dental and mental health) are applicable to the Medicare Bonus Payment program that provides a ten percent bonus payment.

Currently, the Health Resources and Services Administration (HRSA), part of the Department of Health and Human Services, is responsible for designating several types of HPSAs, including HPSA designations based on:

• Areas with shortages of primary care physicians, dentists or psychiatrists, referred to as geographic-based HPSAs; and

• Underserved populations within an area, referred to as population-based HPSAs.

Federal law for Medicare bonus payments recognizes geographic-based, primary medical care, and mental health HPSAs as eligible areas for receiving bonus payments. Consequently, physicians, including psychiatrists, furnishing services in a primary medical care HPSA, are eligible to receive bonus payments.

In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. Dental HPSAs remain ineligible for the bonus payment program due to the fact that Medicare does not cover dental services for its beneficiaries.

This change would only affect psychiatrists furnishing services in mental health HPSAs that do not overlap with primary care HPSAs. In other words, these stand-alone mental health HPSAs are now eligible areas, as of July 1, 2004, for psychiatrists to receive bonus payments.

With respect to psychiatrist services in mental health HPSAs, CMS will furnish quarterly lists of mental health HPSAs to Medicare carriers so they can implement this change which is **effective for claims with dates of service on or after July 1, 2004**. Should an area be both a mental health HPSA and a nonmental health HPSA, only one ten percent bonus payment will apply to a single service.

Also, it is important for physicians and psychiatrists to note that the bonus is paid for services in HPSA areas only if those services are actually provided in the HPSA area. For example, if the physician has an office in a HPSA area, but provides the service in the patient's home, which is outside the service area, the bonus is not payable.

Implementation

The implementation date is July 6, 2004 for the mental health HPSAs and the change for such services will apply effective for dates of service on or after July 1, 2004. For services provided in primary medical care HPSAs, this instruction is meant for clarification and informational purposes only.

Additional Information

The Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 90 (Physicians Practicing in Special Settings), Subsection 90.4 (Billing and Payment in a Health Professional Shortage Areas (HPSAs)) has been revised, and sections have been deleted. You can find this manual at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp Once at that site, scroll down to Chapter 12 and select the version of the file you would like to view. Also, to see the specific instruction issued to your Medicare carrier, visit: http://www.cms.hhs.gov/manuals/pm_trans/R78CP.pdf.

(Reprinted from Medlearn Matters, a publication of CMS).

A dozen ways to improve patient billing

Friendly physicians and attentive staff are not the only ways to boost patient satisfaction. Nor is aggressive collection the only way to improve accounts-receivable performance.

The Patient Friendly Billing Project, a collection of payers, vendors and associations that includes the Medical Group Management Association (MGMA), seeks to boost patient satisfaction and help providers manage their revenue and collection processes. The project's goal is to make the billing process more efficient for medical practices and more understandable to patients.

Consumer research and expert analysis by the Patient-Friendly Billing Task Force outline several steps to attack the billing problems that can delay patient payments. Suggested actions include:

1 Updating patient packets. Make sure credit and collection policies are described clearly. Include a sample patient billing statement;
2 Reviewing the registration process. Try to obtain necessary information from patients as they check in or schedule appointments. Reduce redundant forms;
3 Informing patients. Before a significant episode of care, such as surgery or hospitalization, remind patients of their financial obligations and explain the insurance billing process;
4 Meeting with representatives of major payers periodically. Discuss payment and administrative problems, and seek solutions;
5 Involving physicians and staff. A flow chart describing the revenue cycle – from collecting a copayment at the time of service to billing for a deductible or co-insurance amounts – can help physicians and staff understand their roles in the patient flow process;
6 Giving patients clear billing statements. Make sure summaries of services are easy to understand. Avoid abbreviations and medical jargon. List phone numbers and contact hours;
7 Including return envelopes only when needed. Sending return envelopes with statements that only explain a service just confuses patients;
8 Studying community needs. Ask patients, family members and other caregivers to suggest ways to make billing statements and the billing process clearer. Translating statements into other languages may reach more patients;
9 Considering longer billing-office hours. Inviting patients to call with billing questions during evenings can improve collections and patient satisfaction;
10 Hiring, training and motivating service-oriented staff. Make sure employees understand what various forms are for and how to communicate effectively with patients;
11 Understanding legal and payer requirements. State and federal laws regulate how businesses may bill, offer credit and contact patients for collections; and
12 Understanding the new rules. Work with payers and vendors to make sure your billing systems and practices comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. For more information about HIPAA, go to the Government Affairs area of the MGMA web site at www.mgma.com.

"Every organization that has made these types of changes has seen financial improvement and increased patient satisfaction," says Terry Rappuhn, CPA, principal, Rappuhn Consulting, Nashville, Tenn., who served on the project's vendor task force. "And sometimes they see pretty amazing improvements in accounts receivable and bad-debt performance."

(By Robert Redling, MS, MGMA senior writer).

CONGRATULATIONS . . .

TO DAN HOGGE FOR FINISHING 22ND IN HIS AGE BRACKET IN THE FIRST ANNUAL SALT LAKE MARATHON -- AND FOR RUNNING AN AVERAGE 3:48 MILE!

NOT BAD FOR A GUY HIS AGE!

CMS releases instructions on incident-to services

The Centers for Medicare & Medicaid Services (CMS) clarified in the 2002 physician fee schedule that services incident to a physician's professional service should be billed under the physician on site at the time of service. Incident-to services are services that were initiated by a physician-patient or nonphysician practitioner-patient encounter and are rendered by ancillary personnel in the continuation of diagnosis or treatment prescribed by the provider in the initiating visit. These services must be performed under the direct supervision of a physician in the same group practice, which requires a physician to be immediately available in the office suite and able to provide assistance and direction throughout the time the aide performs the service.

A recent carrier transmittal provides direction for filing a claim in compliance with this instruction. Beginning May 24, practices should comply with the following instructions when billing incident-to services to Medicare on the CMS-1500 claim form:

- Denote the ordering physician or nonphysician practitioner's name and provider number in items 17 and 17a (referring physician name and provider number).
- If the ordering physician is not present at the time of service, enter the supervising physician's provider number (physician present in the office suite at the time of service) in item 24k (reserved for local use).
- Enter the contact information for the identified practitioner in item 24k for item 33 and have this provider sign the claim (item 31).

To view the carrier transmittal: http://www.cms.hhs.gov/manuals/pm_trans/R148CP.pdf

To view the provider education article: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3138.pdf

To view the indicent to regulation: http://a257.g.akamaitech.net/7/257/2422/05dec20031700/edocket.access.gpo.gov/cfr_2003/octqtr/pdf/42cfr410.32.pdf

To view the Medicare Claims Processing Manual instructions on incident-to services: http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf

When is it better to be professionally rude?

Professional courtesy. You want to show respect for other health professionals and their family members, but these days it's a legal minefield.

Give free or discounted care to other physician or their family members or employees, and you could be facing kickback charges or accusations of copayment waivers. Luckily, the fraud watchdogs have clarified the issue recently.

The HHS Office of Inspector General warned of the pitfalls of professional courtesy in its draft compliance plan for individual and small group physician practices. The OIG warned that if you waive the entire fee for services rendered, you shouldn't choose the recipients based on referrals or other business generation. If you waive only copayments, then again it shouldn't take into account referrals. But if you waive copayments for a Medicare beneficiary who isn't financially needy, it may violate a law against offering inducements to beneficiaries.

But more recently, the Phase two interim final rule for the Stark II law offers a whole new exception for professional courtesy, under Section F, "compensation exemptions." The Stark reg says that "you have to offer the same courtesy to everyone in the community," explains attorney Robert Portman with Jenner & Block in Washington. That means all physicians at a local entity or community, plus employees or family members, without regard to referrals.

In the past, some attorneys said the Stark law allowed professional courtesy under the non-monetary compensation exception, which limited non-monetary gifts to $300 per year. But the new exception doesn't limit professional courtesy at all.

This new Stark II provision comes under the category of "be careful what you wish for," says Portman. Physicians may have wanted the feds to clarify the minefield of professional courtesy, but the clarification "forces you to have a level of consistency that most physicians don't want to undertake and undermines the 'courtesy' part of it," says Portman. The only silver lining: if a physician felt pressured to provide professional courtesy in the past, now he or she has a perfect excuse for avoiding it.

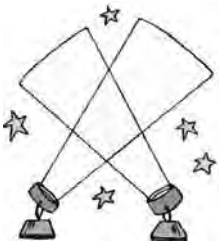
Government limits areas eligible for foreign physicians

Spurred by the Sept. 11, 2001, terrorist attacks on the United States, federal requirements for the foreign-trained physician exchange program have undergone massive changes. Since late 2002, the U.S. Department of Health and Human Services (HHS) processes applications for visa waiver of internationally trained doctors receiving their residency education in the United States. Previously, waivers were processed by the U.S. Department of Agriculture.

Physicians receiving their education abroad and their residency in the United States are required under their visa agreement (J-1 visa) to return to their country following training. The government grants waivers to allow interested primary care and mental health practitioners to remain in the U.S. if they agree to practice for three years in an approved facility or clinic in a health professional shortage area (HPSA). HPSAs are typically rural regions but include some urban areas with physician shortages.

On Dec. 10, 2003, HHS announced that as of Jan. 1, 2004, it will process applications only for facilities located in HPSAs with a need score of 14 or higher. The National Health Service Corps sets the need scale and uses it to identify priority areas for provider assignment. Scores range from 1 to 25, with the highest score representing the greatest priority. It remains unclear how many regions the policy will exclude; however, the restriction on eligible regions will narrow the available assignments for foreign-trained physicians and limit already strained resources available to HPSAs scoring below 14. To determine if your facility is located in an eligible HPSA, calculate your area's need score at http://belize.hrsa.gov/newhpsa/newhpsa.cfm.

(Reprinted from MGMA e-Connexion).



Coming attractions

Association for Ambulatory Behavioral Healthcare
August 9-11, 2004
Boston, MA
http://www.aabh.org/Conf_04/Conf_04menu.htm

Medical Group Management Association
October 3-6, 2004
San Francisco, CA
http://www.mgma.com/education/annconf/

Administrator in Academic Psychiatry/
American Association of Chairs of Departments of Psychiatry Fall Conference
November 5-6, 2004
Boston, MA

National Association of Psychiatric Health Systems
April 17-19, 2005
Washington, DC

The GrAAPvine provides information about educational opportunities of interest to its members. It does not necessarily endorse these programs (except, of course, our own!)

Change in 2004 salary limitation on grants, cooperative agreements and contracts

NOTICE: NOT-OD-04-034
National Institutes of Health (NIH)

This notice provides updated information on the FY 2004 salary limitation. On March 3, 2004, an Executive Order (EO) was signed to implement a retroactive pay increase for Federal employees. This EO, which implements the pay raise approved by Congress in January, applies to certain rates of Federal pay including Executive Level salaries. As a result, the Executive Level I salary level increased, effective January 1, from $174,500 to $175,700. Consistent with NIH's implementation of the FY 2004 salary limitation, if grant awards (competing or non-competing) have already been issued in FY 2004, no adjustments will be made. However, rebudgeting is allowable. Additional details on NIH's implementation of the salary limitation can be found at "Salary Limitation on Grants, Cooperative Agreements, and Contracts" at http://grants.nih.gov/grants/guide/notice-files/NOT-OD-04-025.html.

Questions concerning this notice or other policies relating to grants or contracts should be directed to the grants management or contracts management office in the appropriate NIH Institute or Center.

Inactivation of PA-03-039 – NIMH small grants program

NOTICE: NOT-MH-04-007
National Institute of Mental Health (NIMH)

The NIMH announces that effective immediately, applications will no longer be accepted in response to Program Announcement PA-03-039, NIMH Small Grants Program, which appeared in the NIH Guide on December 4, 2002 at http://grants.nih.gov/grants/guide/pa-files/PA-03-039.html.

Revisions to applications that were previously reviewed under PA-03-039 will be accepted until March 1, 2005.

The NIMH will continue to accept R03 applications under PA-03-108, NIH Small Research Grant Program (R03), http://grants.nih.gov/grants/guide/pa-files/PA-03-108.html.

Applicants are reminded that, under PA-03-039, up to two revisions of a previously reviewed application were allowed, however, under the NIH-wide Small Grant Program (PA-03-108) only one revision of a previously reviewed small grant application may be submitted.

It should also be noted that, under PA-03-039, priority was given to applications falling within 1 of 4 categories under the Research Objectives and explicit justification regarding the relevance of the selected category was a requirement. Under the NIH-wide program announcement, this is no longer a requirement.

Direct your questions about this notice to:

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ACMPE hones hard skills and soft skills (revisited)

by David Peterson, FACMPE

In the Spring 1999 issue of The GrAAPvine, I wrote about some results from an **American College of Medical Practice Executive (ACMPE**)-commissioned Delphi study that ranked "softer," qualitative skills consistently high on a list of desirable medical practice executive leadership skill sets. Qualitative skills such as "trust-building," "listening and responding," "respect," "integrity" and the "ability to adapt to change" were more valued than information technology, spreadsheet and other "hard," quantitative skills. In that column, I offered my own anecdotal experiences that complemented the results of the study. The short version is that to be successful in today's work environment, hard skills just aren't enough if they are not accompanied by softer skills.

It seems the ACMPE was forward-thinking with its survey and the results of the project are still relevant today. A recent *Business Week* (March 22, 2004) article titled "The Future of Work" has as its subtitle: "Flexible, creative and good with people? You should do fine in tomorrow's job market." The article describes "routine" and "non-routine" jobs, noting that the more routine the job, the more replaceable an individual becomes. The article goes on to state that non-routine jobs, those that "cannot be reduced to a recipe," are jobs that require flexibility, creativity and life-long learning. These jobs also require "subtle and frequent interactions with other people, often face-to-face."

For those of us in the field, identifying medical practice management and leadership as a non-routine job is obvious. Flexible? You bet. Subtle (and not so subtle) face-to-face interactions? To be sure. Creative? Without a doubt. Life-long learning? Bingo.

Through its certification exam process and continuing medical education requirement, the ACMPE helps executives hone soft skills and hard skills and it provides a platform for life-long learning. The objective exam measures quantitative skills and the essay exam and presentation requirement require that a hard skill be synthesized with softer skills and successfully communicated to a larger audience either in writing or in a group venue. The award of the **Certified Medical Practice Executive (CMPE)** designation is one indicator of a medical practice leader's success in mastering these skills. Advancement to **Fellow (FACMPE)** status by successfully submitting a professional paper or three case studies takes these skill sets to an even higher level.

By offering a series of continuing medical education (CME) opportunities and awarding and tracking CME credits for its members, the ACMPE helps the successful executive continue on a path of life-long learning. The ACMPE also publishes the *College View*, a semi-annual publication that is soon to take on a new look and name – *ACMPE Executive View*. This newly named and expanded publication will offer "more in-depth information about core competencies (skills) required for effectively performing medical practice executives."

So whether it is about positioning yourself competitively in the marketplace, the satisfaction of testing your skill set, life long learning or enhancing job security, the ACMPE offers a broad menu of options to meet those needs.

For more information on joining the ACMPE or the certification process, contact the ACMPE directly at (303) 397-7869 or contact David Peterson, FACMPE at (414) 456-8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Having that dream again . . .

A guy walks into a psychiatrist's office with a concerned look on his face.

"Doc," he says, "I'm worried. It's that dream. I'm having it again!"

"What dream?" asked the psychiatrist.

"You know," says the man, "the one where I'm into sadism and bestiality and necrophilia. Should I be worried... or am I just beating a dead horse?"

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